Joint Standing Committee on Banking and Insurance

LD 750 **An Act to Establish a Patient's Bill of Rights** **PUBLIC 742**

Sponsor(s)	Committee Report		Amendments Adopted
SAXL J	OTP-AM	A	H-1061
LAFOUNTAIN	OTP-AM	B	H-1165 SAXL J
	OTP-AM	C	

LD 750, which was carried over from the First Regular Session, proposed to incorporate into law many of the provisions contained in the proposed federal patient bill of rights legislation including:

1. Coverage of emergency services;

2. Access to out-of-network providers;

3. Access to obstetrical and gynecological care;

4. Access to specialty care;

5. Continuity of care;

6. Access to prescription drugs;

7. Access to clinical trials;

8. Availability of independent external review of appeals;

9. Prohibition on financial incentives for providers; and

10. Right of enrollees to sue health plans.

Committee Amendment "A" (H-1061) is the majority report of the committee and replaced the bill. The amendment proposed to do the following:

1. It requires all managed care plans to provide reasonable access to providers in accordance with the access standards of Bureau of Insurance Rule Chapter 850.

2. It prohibits carriers offering managed care plans from using financial incentives for participating providers to deny, reduce, withhold, limit or delay specific medically appropriate health care services to enrollees.

3. It requires carriers to provide services requested by enrollees who are deaf or hard-of-hearing or visually impaired during the internal and external review processes.

4. It requires carriers to establish policies to allow enrollees with special conditions to receive standing referrals to specialists.

5. It requires carriers to provide continuity of care to enrollees undergoing a course of treatment when the enrollee's provider is terminated as a participating provider by the carrier or the enrollee's coverage changes to another carrier.

6. It requires coverage of emergency services by carriers in accordance with the requirements of Bureau of Insurance Rule Chapter 850.

7. It requires that carriers provide coverage of routine patient costs for qualified enrollees with life-threatening illnesses that participate in clinical trials. The amendment requires carriers to provide coverage for those costs not reasonably expected to be paid for by the sponsors of an approved clinical trial. Approved clinical trials are defined as clinical research studies and clinical investigations approved and funded by the National Institutes of Health.

8. It requires carriers that provide coverage of prescription drugs through a drug formulary to ensure the participation of physicians and pharmacists in the development of the formulary and to provide exceptions to formulary limitations when a nonformulary drug is medically indicated. The amendment also prohibits carriers from denying coverage of a prescribed drug or device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

9. It creates a process for the independent external review of adverse health care treatment decisions. The amendment allows an enrollee in a health plan to request external review after the enrollee has exhausted all levels of a carrier's internal grievance procedure or has met the requirements for expedited review. An enrollee must request the review in writing within 12 months of the date an enrollee has received a final adverse health care treatment decision under the internal grievance procedure. The adverse health care treatment decisions that may be reviewed are those decisions that involve issues of medical necessity, preexisting condition determinations and determinations regarding experimental or investigational services or decisions regarding diagnosis, care and treatment when medical services are provided by a health plan. The external review decision will be made by an independent review organization under contract with the Department of Professional and Financial Regulation, Bureau of Insurance. The external review decision is binding on the carrier but not on the enrollee.

10. It gives enrollees the right to sue carriers. The amendment creates a statutory cause of action by an enrollee against a carrier offering a health plan or its agents for harm to an enrollee proximately caused by the failure of a carrier to exercise ordinary care when making health care treatment decisions. An enrollee must exhaust the internal and external review processes before bringing a cause of action and must initiate the action within 3 years after the issuance of an external review decision. The right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $400,000. The recovery of punitive damages is precluded.

The amendment also proposed to add an allocation section and a fiscal note to the bill.

Committee Amendment "B" (H-1062) is a minority report of the committee and replaced the bill. The amendment is the same as the majority report except that it does not contain a right-to-sue provision. Committee Amendment "B" was not adopted.

Committee Amendment "C" (H-1063) is a minority report of the committee and replaced the bill. The amendment differed from the majority report in the right-to-sue provision only.

The amendment proposed to give enrollees the right to sue carriers by creating a statutory cause of action by an enrollee against a carrier offering a health plan or its agents for harm to an enrollee directly caused by the failure of a carrier to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee. Under this amendment, an enrollee must exhaust the internal and external review processes before bringing a cause of action and must initiate the action within one year after the issuance of an external review decision; the majority report requires that the action be brought within 3 years. Under this amendment, the right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $150,000 and precludes the recovery of punitive damages. The majority report allows a maximum recovery for noneconomic damages of $400,000

Under this amendment, a carrier has an affirmative defense against a cause of action that the carrier or its agents did not influence, participate in or control the health care treatment decision. The majority report does not provide for an affirmative defense. The amendment also proposed to limit an enrollee's remedy against a carrier for its health care treatment decisions to the statutory cause of action except for other remedies specifically available under other provisions of the Maine Revised Statutes, Title 24-A.

The amendment also proposed to add an allocation section and a fiscal note to the bill. Committee Amendment "C" was not adopted.

House Amendment "A" to Committee Amendment "A" (H-1077) proposed to allow residents of the State to establish medical savings accounts for payment of eligible medical expenses, including the payment of health insurance premiums and deductibles. Contributions to, interest earned on and qualified withdrawals from medical savings accounts would have been exempted from Maine state income tax. House Amendment "A" to Committee Amendment "A" was not adopted.

House Amendment "B" to Committee Amendment "A" (H-1084) proposed to allow health insurers, nonprofit hospital and medical service organizations and health maintenance organizations to offer a catastrophic health plan that does not include any mandated benefits to individuals and small groups. House Amendment "B" to Committee Amendment "A" was not adopted.

House Amendment "C" to Committee Amendment "A" (H-1092) proposed to appropriate $900,000 to the State Employee Health Insurance Reserve to be used in the event that Blue Cross Blue Shield of Maine increases premiums for health insurance provided to state employees due to the effects of the Patient's Bill of Rights. House Amendment "C" to Committee Amendment "A" was not adopted.

House Amendment "D" to Committee Amendment "A" (H-1165) proposed to add clarifying language to the right-to-sue provision and add language giving carriers an affirmative defense. The amendment also proposed to add language making the right-to-sue provision the sole and exclusive remedy against a carrier except for statutory causes of action under the Maine Insurance Code. It also allows a cause of action to be brought seeking remedies under either the right-to-sue provision or under wrongful death, but not both.

House Amendment "E" to Committee Amendment "A" (H-1166) proposed to remove the right-to-sue provision. House Amendment "E" to Committee Amendment "A" was not adopted.

Senate Amendment "A" to Committee Amendment "A" (S-675) proposed to require an enrollee to exhaust the internal and external review processes before bringing a cause of action and must initiate the action within one year after the issuance of an external review decision; Committee Amendment "A" requires that the action be brought within 3 years. Under this amendment, the right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $150,000 and precludes the recover of punitive damages. Committee Amendment "A" allows a maximum recovery for noneconomic damages of $400,000. Senate Amendment "A" to Committee Amendment "A" was not adopted.

Under this amendment, a carrier has an affirmative defense against a cause of action that the carrier or its agents did not influence, participate in or control the health care treatment decision. Committee Amendment "A" does not provide for an affirmative defense. This amendment also limits an enrollee's remedy against a carrier for its health care treatment decisions to the statutory cause of action except for other remedies specifically available under other provisions of the Maine Revised Statutes, Title 24-A. Senate Amendment "A" to Committee Amendment "A" was not adopted.

Enacted law summary

Public Law 1999, chapter 742 establishes additional requirements for health plans and managed care plans offered in this State and provides additional protections for health plan and managed care enrollees.

The law does the following.

1. It requires all managed care plans to provide reasonable access to providers in accordance with the access standards of Bureau of Insurance Rule Chapter 850.

2. It prohibits carriers offering managed care plans from using financial incentives for participating providers to deny, reduce, withhold, limit or delay specific medically appropriate health care services to enrollees.

3. It requires carriers to provide services requested by enrollees who are deaf or hard-of-hearing or visually impaired during the internal and external review processes.

4. It requires carriers to establish policies to allow enrollees with special conditions to receive standing referrals to specialists.

5. It requires carriers to provide continuity of care to enrollees undergoing a course of treatment when the enrollee's provider is terminated as a participating provider by the carrier or the enrollee's coverage changes to another carrier.

6. It requires coverage of emergency services by carriers in accordance with the requirements of Bureau of Insurance Rule Chapter 850.

7. It requires that carriers provide coverage of routine patient costs for qualified enrollees with life-threatening illnesses that participate in clinical trials. The provision requires carriers to provide

coverage for those costs not reasonably expected to be paid for by the sponsors of an approved clinical trial. Approved clinical trials are defined as clinical research studies and clinical investigations approved and funded by the National Institutes of Health. This provision applies to all policies and contracts issued or renewed on or after January 1, 2001.

8. It requires carriers that provide coverage of prescription drugs through a drug formulary to ensure the participation of physicians and pharmacists in the development of the formulary and to provide exceptions to formulary limitations when a nonformulary drug is medically indicated. The provision also prohibits carriers from denying coverage of a prescribed drug or device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use is recognized in one of the standard reference compendia or in peer-reviewed medical literature. This provision applies to all policies and contracts issued or renewed on or after January 1, 2001.

9. It creates a process for the independent external review of adverse health care treatment decisions. The provision allows an enrollee in a health plan to request external review after the enrollee has exhausted all levels of a carrier's internal grievance procedure or has met the requirements for expedited review. An enrollee must request the review in writing within 12 months of the date an enrollee has received a final adverse health care treatment decision under the internal grievance procedure. The adverse health care treatment decisions that may be reviewed are those decisions that involve issues of medical necessity, preexisting condition determinations and determinations regarding experimental or investigational services or decisions regarding diagnosis, care and treatment when medical services are provided by a health plan. The external review decision will be made by an independent review organization under contract with the Department of Professional and Financial Regulation, Bureau of Insurance. The external review decision is binding on the carrier but not on the enrollee.

10. It gives enrollees the right to sue carriers. The provision creates a statutory cause of action by an enrollee against a carrier offering a health plan or its agents for harm to an enrollee proximately caused by the failure of a carrier to exercise ordinary care when making health care treatment decisions affecting the quality of care, diagnosis or treatment provided to an enrollee. An enrollee must exhaust the internal and external review processes before bringing a cause of action and must initiate the action within 3 years after the earlier of the issuance of an external review decision or the issuance of an underlying adverse first-level appeal or grievance determination notice. The right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $400,000. The recovery of punitive damages is precluded. The provision gives carriers an affirmative defense that the carriers or its agents did not influence, participate in or control the health care treatment decision. The provision also makes the cause of action the sole and exclusive remedy against a carrier except for statutory causes of action under the Maine Insurance Code. It also allows a cause of action to be brought seeking remedies under either the right-to-sue provision or under the wrongful death statute, but not both.

LD 1000 **An Act to Provide Insurance Parity for Substance Abuse Treatment** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
DAGGETT	ONTP	

LD 1000, which was carried over from the First Regular Session, proposed to require that all individual and group health insurance contracts provide coverage for substance abuse treatment under the same terms and conditions as coverage for physical conditions and illnesses. The bill would have applied to all policies and contracts issued or renewed on or after January 1, 2000.

LD 1158 **An Act to Ensure Equality in Mental Health Coverage for Children and Adults** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
BROOKS PARADIS	ONTP	

LD 1158, which was carried over from the First Regular Session, proposed to require that all individual and group health insurance contracts provide coverage for biologically-based mental illness under the same terms and conditions as coverage for physical illness. The bill proposed to add the eating disorders, anorexia and bulimia, to the list of biologically-based mental illnesses that qualify for parity coverage. LD 1158 also proposed to require that all health insurance contracts provide parity coverage for all mental illnesses and disorders diagnosed in children under 18 years of age listed in the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition.

LD 1493 **An Act Regarding Private Long-term Disability Insurance for Mental Illnesses** **ONTP**

Sponsor(s)	Committee Report		Amendments Adopted
PERRY	ONTP	MAJ	
	OTP	MIN	

LD 1493, which was carried over from the First Regular Session, proposed to require all long-term disability insurance policies or contracts offered by group or individual insurers to cover disabilities resulting from certain biologically-based mental illnesses. These mental illnesses would have included major depressive disorder, schizophrenia, obsessive-compulsive disorder, panic disorder, paranoia, bipolar disorder and autism.

LD 1619 **An Act to Create a Patients' Bill of Rights** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
LAWRENCE	ONTP	

LD 1619, which was carried over from the First Regular Session, proposed to establish a "Patients' Bill of Rights" for Maine residents enrolled in HMO's and other health plans. The bill proposed to:

1. Ensure access to obstetrical and gynecological care;

2. Ensure access to specialty care for seriously ill patients;

3. Ensure continuity of care when a physician is dropped from a health plan;

4. Ensure access to prescription drugs;

5. Ensure access to clinical trials;

6. Provide patients with access to an independent external review of decisions regarding health care coverage and services;

7. Prohibit offering financial incentives to providers to limit necessary and appropriate medical care;

8. Establish an independent consumer assistance program to provide assistance and advocacy services to patients in selecting a health insurance plan, utilizing the plan and filing grievances and appeals of plan decisions;

9. Provide patients with the right to sue their health plan if the plan's failure to exercise ordinary care in making treatment decisions causes an injury to a patient; and

10. Require health plans to disclose information about their costs, benefits and performance.

See related bill, LD 750.

LD 1640 **An Act Regarding Service Contracts** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
ABROMSON	ONTP	

LD 1640, which was carried over from the First Regular Session, proposed to establish regulatory standards for providers of service contracts and exempt these contracts from all other provisions of the Maine Insurance Code. The bill also proposed to exempt from the Maine Insurance Code other types of contracts, including warranties, maintenance agreements, service contracts offered for sale to persons other than consumers and warranties, service contracts and maintenance agreements offered by public utilities on their transmission devices to the extent they are regulated by the Public Utilities Commission.

LD 1787 **An Act Regarding Dependent and Family Coverage in the State Employee Health Insurance Program** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
DAGGETT	ONTP	

LD 1787, which was carried over from the First Regular Session, proposed to require the state employee health insurance program to treat the children of 2 unmarried state employees the same as it does the children of 2 married state employees when offering and establishing costs for health insurance. The bill proposed to require the state to offer so-called "split contracts" to unmarried state employees on the same basis and cost as if offered to married state employees.

LD 2029 **An Act to Update and Amend the Preferred Provider Arrangement Act** **PUBLIC 609**

Sponsor(s)	Committee Report	Amendments Adopted
SAXL J ABROMSON	OTP-AM	H-860

LD 2029 was submitted on behalf of the Department of Professional and Financial Regulation and carried over from the First Regular Session. LD 2029 proposed to accomplish the following:

1. It makes definitions in the Maine Revised Statutes, Title 24-A, chapter 32 more consistent with those in Title 24-A, chapter 56-A;

2. It adds geographic accessibility standards for preferred provider arrangements, consistent with those of health maintenance organizations;

3. It provides for the incorporation of downstream risk arrangements;

4. It requires a preferred provider administrator who handles money to be licensed as a 3rd-party administrator, rather than being subject to separate standards as they are currently; and

5. It requires registered preferred provider arrangements to generate annual reports consistent with existing law.

Committee Amendment "A" (H-860) replaced the bill.

Preferred provider arrangements, PPAs, include a contract, agreement or arrangement between a carrier or administrator and a provider in which the provider agrees to provide health care services to a health plan enrollee whose plan benefits include incentives, typically a discount, for the enrollee to use the services of that provider. PPAs often serve as the provider network for carriers offering discount arrangements. In some instances, a PPA is the provider network for health maintenance organizations, HMOs. A gatekeeper PPA mirrors an HMO point-of-service product. Because of the similarities between a PPA and an HMO, the amendment proposed to standardize the reporting and filing requirements.

The amendment proposed to clarify definitions in the PPA statute and make the definitions consistent with the HMO statute. The amendment would make the accessibility and reporting standards for PPAs and HMOs consistent. It also clarified the information that PPAs must file with the Superintendent of Insurance to be registered in the State. The amendment proposed to require preferred provider administrators who transfer funds, manage funds or adjust claims to register as insurance administrators. The amendment would require that carriers offering more than one health plan with different provider networks must register each arrangement as a separate PPA with the superintendent. The amendment would clarify that the rules adopted pursuant to the Maine Revised Statutes, Title 24-A, chapter 56-A are applicable to PPAs.

The amendment proposed to require providers that enter into limited risk arrangements to meet certain criteria to protect enrollees from financial risk. Carriers that enter into downstream risk arrangements with downstream entities must acknowledge responsibility for providing services to enrollees in the event a downstream entity fails financially. Under the amendment, Title 24-A, chapter 56-A, subchapter III would allow the waiver of licensure requirements for downstream risk arrangements that meet safe harbor provisions or meet additional contractual and disclosure requirements specified by the superintendent. This subchapter proposed to establish a risk threshold under which a downstream entity may operate without licensure. Specific contractual and disclosure provisions are established that downstream entities must comply with to meet safe harbor standards. Additionally, the superintendent may waive licensing requirements for downstream entities that exceed the risk threshold if they meet specific contractual and disclosure conditions.

The amendment also added a fiscal note to the bill.

Enacted law summary

Public Law 1999, chapter 609 makes changes to the laws governing preferred provider arrangements to make them more consistent with the laws governing health maintenance organizations. A preferred provider arrangement is a contract, agreement or arrangement between a health insurance carrier or administrator and a provider in which the provider agrees to provide health care services to a health plan enrollee whose plan benefits include incentives, typically a discount, for the enrollee to use the services of that provider. Because of the similarities between a preferred provider arrangement (PPA) and a health maintenance organization (HMO), Public Law 1999, chapter 609 standardizes the reporting and filing requirements for PPAs and HMOs and makes the definitions consistent with those used in the Maine Revised Statutes, Title 24-A, chapter 56.

Public Law 1999, chapter 609 also makes the accessibility standards for PPAs consistent with the standards for HMOs. It clarifies the information that PPAs must file with the Superintendent of Insurance to be registered in the State. It requires administrators of preferred provider arrangements who transfer funds, manage funds or adjust claims to register as insurance administrators. The law requires that carriers offering more than one health plan with different provider networks must register each arrangement or provider network as a separate PPA with the Superintendent of Insurance. Finally, the law makes the rules adopted pursuant to the Health Plan Improvement Act, Maine Revised Statutes, Title 24-A, chapter 56-A, applicable to PPAs.

Public Law 1999, chapter 609 also enacts a new subchapter regulating downstream risk arrangements. Under a downstream risk arrangement, providers enter into arrangements with carriers that transfer all or part of the financial risk from a carrier's health plan to the provider. The law requires that downstream risk

arrangements be licensed or expressly permitted by the Superintendent unless the arrangements meet certain criteria under which a downstream entity may operate without licensure or obtain a waiver from the Superintendent. Downstream risk arrangements between a carrier and a downstream entity may operate without licensure if the arrangements do not involve substantial insurance risk or substantial enrollee risk and the arrangements meet specific contractual and disclosure requirements. Substantial insurance risk is defined as risk based on the use or costs of referral services only when the downstream entity is at risk for more than 75% of potential payments by the carrier to the downstream entity. Substantial enrollee risk is defined as an arrangement with a downstream entity involving more than 25% of the enrollees served by the carrier. Downstream risk arrangements that exceed the risk threshold for insurance risk or enrollee risk may request and receive a waiver from licensure from the Superintendent. The waiver request must include a plan for managing financial exposure sufficient to quantify in dollars per quarter and per annum all elements of downstream risk to be assumed by the downstream entity.

LD 2043 **An Act to Clarify Underinsured Motor Vehicle Coverage** **PUBLIC 663**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN SAXL J	OTP-AM	S-572

LD 2043 was recommitted to the Joint Standing Committee on Banking and Insurance near the end of the First Regular Session and carried over to the Second Regular Session. LD 2043 proposed to amend the laws governing underinsured vehicle coverage to address certain cases when more than one person is injured in an accident. It proposed to amend the provision of law construed in Mullen v. Liberty Mutual Insurance Co., 589 A.2d 1275 (Me. 1991) to deny a consumer the full benefit of the purchased insurance coverage in certain circumstances.

In Mullen v. Liberty Mutual Insurance Co., the Supreme Judicial Court determined that under current law the victim of a negligent motorist may be denied the full benefit of the uninsured motorist insurance purchased if multiple people are injured. LD 2043 proposed to amend the provision of law construed in Mullen to ensure that a person who is injured in an automobile accident is covered to the full extent of the underinsured motorist coverage purchased by the injured person when the insurance policy of the negligent motorist does not cover the injured person's claims.

Committee Amendment "B" (S-572) replaced the bill. The amendment proposed to require that, in instances when more than one person is injured in a motor vehicle accident involving an underinsured motor vehicle, the amount of underinsured vehicle coverage available to the injured person is determined by subtracting any payments actually made to the injured person under the motor vehicle liability policy applicable to the particular owner or operator of the underinsured motor vehicle from the injured person's, operator's or owner's underinsured vehicle coverage policy limits if applicable to that person. The amount of recovery must also be reduced by the amount by which the policy limits of the motor vehicle liability policy covering the underinsured motor vehicle exceed the total payments made under that policy to injured persons.

The amendment also proposed to clarify that the requirement that uninsured motor vehicle coverage limits equal the amount of liability coverage under a policy unless lower amounts are expressly rejected applies to personal motor vehicle insurance coverage and not to commercial coverage. It adds a provision governing the manner and time frame in which purchasers of personal motor vehicle insurance coverage may reject

equal amounts of coverage. It also specifies the language that must be included in the rejection form provided to purchasers by insurers. The amendment makes this provision applicable to all motor vehicle liability policies issued or renewed on or after October 1, 2000.

The amendment also proposed to add an emergency preamble and emergency clause to the bill.

Enacted law summary

Public Law 1999, chapter 663 amends the statutory provisions governing underinsured vehicle coverage in situations when more than one person is injured in a motor vehicle accident involving an underinsured motor vehicle. In these situations, the law requires that the amount of underinsured vehicle coverage available to the injured person is determined by subtracting any payments actually made to the injured person under the motor vehicle liability insurance policy applicable to the particular owner or operator of the underinsured motor vehicle from the injured person's, operator's or owner's underinsured vehicle coverage policy limits if applicable to that person. The amount of recovery must also be reduced by the amount by which the policy limits of the motor vehicle liability insurance policy covering the underinsured motor vehicle exceed the total payments made under the policy to the injured person.

Public Law 1999, chapter 663 also clarifies the provision in Public Law 1999, chapter 271 requiring that the uninsured motor vehicle coverage limits of a motor vehicle insurance policy equal the amount of liability coverage under the policy unless lower amounts of coverage are expressly rejected. Public Law 1999, chapter 663 makes clear that this requirement applies to personal motor vehicle insurance coverage and not to commercial coverage. It prescribes the manner and time frame in which purchasers of personal motor vehicle insurance coverage may reject equal amounts of coverage and specifies the language that must be included in the rejection form provided to purchasers by insurers. Finally, Public Law 1999, chapter 663 delays the implementation of the requirement for equal amounts of coverage for uninsured coverage and liability coverage to all personal motor vehicle liability insurance policies issued or renewed on or after October 1, 2000.

Public Law 1999, chapter 663 was enacted as an emergency effective April 11, 2000.

LD 2058 **An Act Relative to Insurance Compliance Self-audit** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
MAYO ABROMSON	ONTP	

LD 2058, which was carried over from the First Regular Session, proposed to create a privilege for self-audit documents maintained by insurers to monitor and facilitate compliance with the Maine Insurance Code. The bill proposed to limit discovery of the self-audit documents in civil, criminal or administrative proceedings against an insurer except in certain circumstances. The bill also proposed to make self-audit documents submitted to the Bureau of Insurance confidential after submission and to specify that the self-audit privilege is not waived after submission of the documents. The bill would not have extended the privilege in civil fraud cases or in criminal proceedings if a court ordered disclosure after review of the documents in camera.

LD 2138 **An Act to Permit the Transfer of Liabilities by a Member of a Workers' Compensation Group Self-insurer** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
SAXL M	ONTP	

LD 2138, which was carried over from the First Regular Session, proposed to enable a member of a workers' compensation self-insured group to withdraw from the group with the approval of the group by insuring the departing member's own liabilities arising from that member's own claims that would otherwise remain the responsibility of the group. It further would authorize the Superintendent of Insurance to approve insurance policy endorsements that would accomplish this.

LD 2225 **An Act to Permit Certain Referrals by Health Care Practitioners** **PUBLIC 553 EMERGENCY**

Sponsor(s)	Committee Report	Amendments Adopted
SAXL M	OTP-AM	H-786

Current law prohibits a health care practitioner from referring a patient to another facility in which the practitioner holds an interest unless the practitioner will be personally responsible for the provision of care to that patient. LD 2225 proposed to allow the referral to another office or group of health care practitioners, regardless of whether the referring physician holds an investment interest in that office or group.

Committee Amendment "A" (H-786) proposed to allow a health care practitioner to refer patients to another health care practitioner in a group practice or health care facility in which the referring health care practitioner has invested when there is a demonstrated need for the facility in the community. The amendment specifies that demonstrated need for the facility exists when the quality of health care services in the community would be improved, such as when the facility provides new specialty or subspecialty services.

The amendment also added a fiscal note to the bill.

Enacted law summary

Public Law 1999, chapter 553 removes the prohibition on a health care practitioner from referring a patient to another facility in which that practitioner holds a financial interest to allow a practitioner to refer patients to another health care practitioner in a group practice or health care facility in which the referring practitioner has invested when there is a demonstrated need for the facility in the community.

Public Law 1999, chapter 533 was enacted as an emergency effective March 15, 2000.

LD 2259 **An Act to Amend the Maine Banking Code Pertaining to Interlocking Directors** **PUBLIC 546 EMERGENCY**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN	OTP-AM	S-477

LD 2259 proposed to amend the Maine Banking Code pertaining to laws that affect bank directors. The changes amend the interlocking directors provisions, which need to be changed after Maine's recent adoption of the universal bank charter laws, to allow a director of a traditional bank or credit union to also serve on the board of a financial institution with a limited purpose charter with a waiver from the Superintendent of Banking.

Committee Amendment "A" (S-477) proposed to clarify that any waiver granted by the Superintendent of Banking may be withdrawn upon reasonable written notice to the affected party. The amendment also proposed to add an emergency preamble, emergency clause and a fiscal note to the bill.

Enacted law summary

Public Law 1999, chapter 546 amends the law prohibiting interlocking directors on the boards of more than one financial institution to allow an individual to serve on the board of a limited purpose bank and a traditional financial institution or credit union with a waiver from the Superintendent of Banking.

Public Law 1999, chapter 546 was enacted as an emergency effective March 6, 2000.

LD 2263 **An Act to Regulate Nonprofit Debt Management Service Providers** **PUBLIC 560 EMERGENCY**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN	OTP-AM	S-493

LD 2263 proposed to amend the Maine Consumer Credit Code by enacting a new article providing for the registration and regulation of nonprofit debt management service organizations.

Committee Amendment "A" (S-493) replaced the bill and proposed to enact a new chapter requiring the registration and regulation of nonprofit debt management service providers. Such organizations assist consumers in restructuring their consumer credit obligations and revising their terms of repayment on a voluntary basis, generally by also securing debt restructuring agreements with creditors. Payments made by a consumer do not become the property of the organization and must be deposited in a trust account and paid over to the creditors within 15 days, according to the terms of a written agreement with the consumer. The amendment proposed to give the Office of Consumer Credit Regulation regulatory authority over nonprofit debt management service providers.

The amendment also proposed to add an emergency preamble, an emergency clause and a fiscal note to the bill.

Enacted law summary

Public Law 1999, chapter 560 requires the registration and regulation of nonprofit debt management service providers by the Department of Professional and Financial Regulation, Office of Consumer Credit Regulation. For-profit organizations that provide debt management services are prohibited. Nonprofit debt management service providers provide services on a voluntary basis to consumers to restructure their consumer credit obligations and to revise their terms of repayment, often by securing debt restructuring agreements with creditors.

Public Law 1999, chapter 560 requires that consumer funds be deposited in a trust account and be paid over to creditors on the consumer's behalf within 15 days of receipt of the funds. It prohibits debt management service providers from performing debt management services for a consumer unless the services are provided pursuant to a written agreement with the consumer. Debt management service providers are also prohibited from purchasing debt, providing credit to consumers, operating as a debt collector, obtaining a mortgage or other security interest in a consumer's property and structuring agreements that would result in negative amortization of a consumer's obligations to creditors.

Public Law 1999, chapter 560 was enacted as an emergency effective March 15, 2000.

LD 2264 **An Act Relating to Certain Commercial Insurance Contracts** **PUBLIC 538**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN	OTP-AM	S-472

LD 2264 proposed to amend the definition of large commercial policyholder to clarify that the premium threshold for property and casualty insurance premiums remains $50,000 after January 1, 2003.

Committee Amendment "A" (S-472) proposed to correct a cross-reference.

Enacted law summary

Public Law 1999, chapter 538 clarifies that a large commercial policyholder must continue to satisfy the $50,000 premium threshold for property and casualty insurance after January 1, 2003 in order to qualify for reduced regulation of large commercial insurance policies by the Bureau of Insurance.

Public Law 1999, chapter 538 applies retroactively to September 18, 1999.

LD 2283 **An Act to Realign Capital Requirements for Specialty Bank Charters** **PUBLIC 539**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN	OTP	

Current law requires initial capital for a merchant bank of $20,000,000, considerably more than that required for any other financial institution chartered under state law. LD 2283 proposed to realign that minimum capital requirement to be consistent with that which is required for any other bank charter and make other changes in specialty bank laws to create uniformity with respect to statutory capital requirements.

Enacted law summary

Public Law 1999, chapter 539 makes the minimum capital required for merchant banks consistent with the requirement for other bank charters.

LD 2296 **An Act to Clarify the Rule-making Authority of the Commissioner of Human Services in Relation to Health Maintenance Organizations and Other Health Plans** **DIED BETWEEN BODIES**

Sponsor(s)	Committee Report		Amendments Adopted
LAFOUNTAIN	OTP-AM	MAJ	
	ONTP	MIN	

Current law grants rule-making authority over health maintenance organization's quality matters and other matters that are within the purpose of the Health Plan Improvement Act to the Superintendent of Insurance.

The Bureau of Medical Services within the Department of Human Services proposed a new department rule: 10-144, chapter 109, Quality Oversight for Commercial Health Maintenance Organizations, that would give authority to the Bureau of Medical Services to oversee quality assurance for commercial health maintenance organizations that are subject to primary regulation and oversight by the Bureau of Insurance.

LD 2296 proposed to prohibit the Commissioner of Human Services from adopting rules relating to quality oversight for commercial health maintenance organizations or other health plans that are subject to the Health Plan Improvement Act.

Committee Amendment "A" (S-608) is the majority report of the committee and replaced the bill. The amendment proposed to designate any rules of the Department of Human Services that relate to quality oversight of health maintenance organizations and other carriers as major substantive rules subject to legislative review by the Joint Standing Committee on Banking and Insurance. Committee Amendment "A" was adopted in the House, but was not adopted in the Senate.

LD 2373 **An Act to Prevent Misuse of Mortuary Trust Funds** **PUBLIC 590**
EMERGENCY

Sponsor(s)	Committee Report	Amendments Adopted
GOLDTHWAIT STANWOOD	OTP-AM	S-521

LD 2373 proposed to amend the laws governing mortuary trust funds as follows.

1. It requires that, if money is paid by check, share draft or money order under a prearranged funeral or burial plan, the payee must instruct the payor to make the instrument payable to the financial institution into which it is to be deposited.

2. It requires prearranged funeral and burial plan agreements to state the name of the financial institution into which the money will be deposited and directs the payor to send a copy of the agreement to the named institution.

3. It requires the payee to keep complete records, including the name and address of the institution currently in possession of the funds.

4. Current law allows the payee to withdraw funds on the instructions of the payor. The bill allows the payee only to direct the funds to another institution or to the payor. The funds may be withdrawn by the payee only upon the death of the beneficiary.

Committee Amendment "A" (S-521) proposed to require that the names of the mortuary trustee and the person for whose benefit the payment is made appear on the check, share draft or money order made payable to the financial institution or credit union into which mortuary trust funds are to be deposited. The amendment also would require that withdrawal of mortuary trust funds may be made only upon presentation of a certified copy of the death certificate of the person for whose benefit the funds were paid. The amendment also would clarify the liability of a financial institution or credit union for payment of funds in a mortuary trust account.

The amendment also proposed to add an emergency preamble, emergency clause and a fiscal note to the bill.

Enacted law summary

Public Law 1999, chapter 590 changes the laws governing mortuary trust funds.

1. It requires that if money is paid by check, share draft or money order under a prearranged funeral or burial plan, the funeral director must instruct the individual making the payment to make the instrument payable to the financial institution into which the funds are to be deposited and to include the names of the funeral director as mortuary trustee and the person for whose benefit the payment is made on the check, share draft or money order.

2. It requires that prearranged funeral and burial plan agreements state the name of the financial institution into which the money is to be deposited and directs the individual establishing the plan to send a copy of the agreement to that financial institution.

3. It to requires the funeral director or mortuary trustee to keep complete records, including the name and address of the financial institution or credit union where the funds are currently deposited.

4. It requires that funds may only be transferred to another institution or directed to the person who established the fund.

5. It requires that funds may be withdrawn by the mortuary trustee only upon presentation of a certified copy of the death certificate of the person for whose benefit the funds were paid.

Public Law 1999, chapter 590 was enacted as an emergency effective March 28, 2000.

LD 2408 **Resolve, to Create a Blue Ribbon Commission to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for all Maine Citizens** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
SAXL J	ONTP	

LD 2408, which was a concept draft pursuant to Joint Rule 208, proposed to create a blue ribbon commission to study the creation of a public/private purchasing alliance in order to ensure access to health care for all Maine citizens.

See related joint order, HP 1857.

LD 2423 **An Act to Allow Privately Acquired Catastrophic Insurance Coverage to Supplement the Cub Care Program** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
SHERMAN	ONTP	

LD 2423 proposed to modify the Cub Care law to allow retention of privately provided catastrophic insurance coverage for children, which would serve to supplement coverage under the Cub Care program.

LD 2424 **An Act to Require Health Insurance Policies to Cover School-based Services** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
FULLER MITCHELL B	ONTP	

LD 2424 proposed to require health insurance policies and contracts that cover children in school to cover services performed by a physician, nurse practitioner or physician assistant who is employed or contracted to provide those services by an elementary or secondary school. The bill also proposed to require the Department of Human Services to adopt rules no later than October 1, 2000 to ensure coverage of those same services under Medicaid.

See related joint order, HP 1864.

LD 2520 **An Act to Amend Investment-related Provisions of the Maine Insurance Code** **PUBLIC 715**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN SULLIVAN	OTP-AM	S-663

LD 2520 proposed to rewrite certain provisions of the Maine Insurance Code dealing with investments of life and health insurers, including investments in affiliates, foreign investments, encumbrance of securities and limits on both mortgage loans and the use of derivative investments. It would replace portions of current Maine law with provisions drawn from the Investment of Insurers Model Act developed by the National Association of Insurance Commissioners, or "NAIC," and adopted in a number of other states. LD 2520 proposed to do the following:

1. It adds a number of definitions to Maine's investment law to implement the provisions of this bill and repeals the definition of "bona fide hedging transaction."

2. It addresses hedging and other uses of derivative investment instruments, consistent with the model investment law and more recent regulatory developments in other states. It places new limits on the use of derivatives by life and health insurers, while at the same time updating Maine law to recognize the evolution in this area.

3. It amends the diversification requirements of Maine's investment law to specifically apply to derivative transactions, counter-party exposure amounts, securities lending transactions, reverse repurchase transactions, repurchase transactions and dollar roll transactions.

4. It imposes limits on mortgage lending by life and health insurers not now imposed in Maine law. The limits are similar to those contained in the NAIC model investment law.

5. It expands the limitations on foreign investments to match those in the model investment law, allowing Maine life and health insurers greater access to maturing global capital markets.

6. It amends the Maine Revised Statutes, Title 24-A, section 1160, subsection 3 to address a conflict between Maine's investment law and its insurance holding company law with respect to transactions with affiliates. It is consistent with the model law. The result of amending this section is to allow Title 24-A, section 222, subsection 9, paragraph E, subparagraph (1), division (b) to be the exclusive source of regulation on this issue, eliminating confusion caused by the current overlap and inconsistency of the 2 provisions.

7. It addresses ambiguities as to the applicability to securities lending, repurchase, and reverse repurchase transactions of the limits on the percentage of an insurer's assets that may be pledged to secure borrowings by the insurer. The bill also increases the limits to be consistent with the model investment law.

Committee Amendment "A" (S-663) proposed to clarify that the additional definitions and changes to definitions included in the bill apply to life and health insurers. Under the amendment, the definitions in current law as they apply to property and casualty insurers are retained. The amendment proposed to authorize life and health insurers and property and casualty insurers to invest in depository institution subsidiaries to the extent allowed under federal law.

The amendment also proposed to amend the provision governing insurance company transactions with affiliates to address a conflict with the insurance holding company law and makes the holding company law the exclusive source of regulation of transactions with affiliates.

The amendment proposed to address ambiguities concerning how the limits on the percentage of an insurer's assets that may be pledged to secure borrowings by the insurer apply to securities lending and repurchase and reverse repurchase transactions.

Finally, the amendment proposed to make technical changes and other clarifications to the bill.

Enacted law summary

Public Law 1999, chapter 715 rewrites certain provisions of the Maine Insurance Code relating to permissible investments of life and health insurers, including investments in affiliates, foreign investments, encumbrance of securities and limits on both mortgage loans and the use of derivative investments. The new provisions are based on the Investment of Insurers Model Act developed by the National Association of Insurance Commissioners. The law clarifies that the changes to definitions and additional definitions apply only to life and health insurers. The definitions in current law are retained without changes as they apply to property and casualty insurers.

The law authorizes life and health insurers and property and casualty insurers to invest in depository institution subsidiaries to the extent allowed under federal law.

Public Law 1999, chapter 715 also amends the provision governing insurance company transactions with affiliates to address a conflict with the insurance company holding law. The law makes the holding company law the exclusive source of regulation of transactions with affiliates.

LD 2574 **An Act to Harmonize State Financial Services Laws with Federal Law** **PUBLIC 656 EMERGENCY**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN SAXL J	OTP-AM	S-589

LD 2574 proposed to amend the Charitable Solicitations Act to exempt federally-chartered and state-chartered financial institutions and credit unions that are subject to supervision and examination by their respective chartering authorities.

LD 2574 also proposed to permit mutual property and casualty insurance companies in Maine to adopt a mutual holding company structure. The bill was introduced because of a provision of the federal Financial Services Modernization Act of 1999. Unless a state's laws authorize mutual insurers to transfer their domicile to another state and reorganize as a stock insurance company owned by a mutual holding company, the federal law preempts state insurance laws for this type of reorganization. Maine law does not currently authorize that kind of reorganization. By establishing law to allow mutual property and casualty insurers to reorganize, LD 2574 proposed to end the federal preemption and provide flexibility to mutual property and casualty insurers organized in Maine.

Committee Amendment "A" (S-589) proposed to clarify that a health insurance company organized as a mutual insurer may reorganize through the formation of a mutual holding company. The amendment also proposed to remove the provision in the bill that would have allowed challenges to a decision of the Superintendent of Insurance to approve the reorganization of a mutual insurer through the formation of a mutual holding company to be brought up to 180 days after the superintendent's approval of the plan.

The amendment also proposed to add an emergency preamble, emergency clause and fiscal note to the bill.

Enacted law summary

Public Law 1999, chapter 656 exempts federally-chartered and state-chartered financial institutions and credit unions that are subject to supervision and examination by their respective chartering authorities from the Charitable Solicitations Act.

Public Law 1999, chapter 656 also permits mutual property and casualty or health insurance companies to reorganize through the formation of a mutual holding company in response to the federal Financial Services Modernization Act of 1999. Unless a state's laws authorize mutual insurers to transfer their domicile to another state and reorganize as a stock insurance company owned by a mutual holding company, the federal law will preempt state insurance laws for this type of reorganization. Since Maine law did not previously authorize mutual insurers domiciled in the State to adopt the mutual holding company structure, Public Law 1999, chapter 656 ends the federal preemption.

Public Law 1999, chapter 656 was enacted as an emergency effective April 10, 2000.

LD 2627 **An Act to Create the Community Health Plan Demonstration Project** **ONTP**

Sponsor(s)	Committee Report		Amendments Adopted
SAXL M	ONTP	MAJ	
GOLDTHWAIT	OTP	MIN	

LD 2627 proposed to create a Community Health Plan Demonstration Project to be implemented by the Mount Desert Island Community Health Plan with oversight from the Superintendent of Insurance and the Department of Human Services. The target population of the project is small employers and self-insured employers. The purpose of the project is to determine the economic viability and health care quality associated with a community-based health plan providing access to affordable health care to participating purchasers through a purchasing alliance while at the same time providing a reasonable reimbursement to participating health care providers and maintaining local community control.

The bill also proposed to make an appropriation for the Community Health Plan Demonstration Project Guaranty Fund to cover potential losses incurred by the target risk pool during the 3-year benefit period under the project.

See related joint order, HP 1857.

HP 1857 **JOINT ORDER – Relative to the Joint Select Committee to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for all Maine Citizens** **PASSED**

Sponsor(s)	Committee Report	Amendments Adopted
SAXL J		S-720 PINGREE
ABROMSON		

Joint Order HP 1857, proposed to establish a joint select committee to study the creation of a public/private purchasing alliance to ensure access to health care for all Maine citizens. The select committee would have consisted of the 13 members of the Joint Standing Committee on Banking and Insurance and would have been charged with studying the public policy, regulatory and legislative issues related to the creation of a purchasing alliance. The joint order proposed to have the select committee submit a report, along with any recommended legislation, by December 1, 2000.

Senate Amendment "A" to HP 1857 proposed to include in the committee's duties the possibility of creating a pilot project for a community-based health plan. Senate Amendment "A" was not adopted.

Senate Amendment "B" to HP 1857 proposed to change the membership of the committee from 13 members of the Joint Standing Committee on Banking and Insurance to 5 members who serve as legislators. The amendment also proposed to include in the committee's duties the possibility of creating a pilot project for a community-based health plan. Senate Amendment "B" was adopted in the Senate, but was not adopted in the House.

Senate Amendment "C" to HP 1857 proposed to change the membership of the committee to 13 legislators with preference to members of the Joint Standing Committee on Banking and Insurance; to change the deadline for the first meeting of the committee; and to include in the committee's duties the possibility of creating a pilot project for a community-based health plan.

Enacted law summary

Joint Order HP 1857 establishes a joint select committee to study the creation of a public/private purchasing alliance to ensure access to health care for all Maine citizens. The select committee consists of 13 members and is charged with studying the public policy, regulatory and legislative issues related to the creation of a public/private purchasing alliance. The joint order requires the select committee to submit a report, along with any recommended legislation, by December 1, 2000.

HP 1864 **JOINT ORDER – Relative to the Joint Select Committee on School-based Health Care Services** **PASSED**

Sponsor(s)	Committee Report	Amendments Adopted
FULLER		S-721 PINGREE

Joint Order HP 1864 proposed to establish a joint select committee to study school-based health services. The select committee would have consisted of 5 members and was charged with studying the current funding sources for school-based health services, including the ability of school-based health centers to receive insurance reimbursement from 3rd party payors. The joint order proposed to have the select committee to submit a report, along with any recommended legislation, by December 1, 2000.

Senate Amendment "A" to HP 1864 proposed to change the date of the first meeting of the select committee from May 15, 2000 to June 30, 2000. The amendment also proposed to clarify that members are compensated for attendance only at authorized meetings of the committee.

Enacted law summary

Joint Order HP 1864 establishes a joint select committee to study school-based health services. The select committee consists of 5 members and is charged with studying the current funding sources for school-based health services, including the ability of school-based health centers to receive insurance reimbursement from 3rd party payors. The select committee is required to submit a report, along with any recommended legislation, to the Legislature by December 1, 2000.

LD INDEX